Senate

General Assembly

File No. 425

January Session, 2023

Substitute Senate Bill No. 986

Senate, April 4, 2023

The Committee on Public Health reported through SEN. ANWAR of the 3rd Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT PROTECTING MATERNAL HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 19a-490 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

As used in this chapter, unless the context otherwise requires:

(a) "Institution" means a hospital, short-term hospital special hospice, hospice inpatient facility, residential care home, nursing home facility, home health care agency, home health aide agency, behavioral health facility, assisted living services agency, substance abuse treatment facility, outpatient surgical facility, outpatient clinic, clinical laboratory, <u>birth center,</u> an infirmary operated by an educational institution for the care of students enrolled in, and faculty and employees of, such institution; a facility engaged in providing services for the prevention, diagnosis, treatment or care of human health conditions, including facilities operated and maintained by any state agency; and a residential facility for persons with intellectual disability licensed pursuant to

section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disability. "Institution" does not include any facility for the care and treatment of persons with mental illness or substance use disorder operated or maintained by any state agency, except Whiting Forensic Hospital and the hospital and psychiatric residential treatment facility units of the Albert J. Solnit Children's Center;

(b) "Hospital" means an establishment for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions and includes inpatient psychiatric services in general hospitals;

(c) "Residential care home" or "rest home" means a community residence that furnishes, in single or multiple facilities, food and shelter to two or more persons unrelated to the proprietor and, in addition, provides services that meet a need beyond the basic provisions of food, shelter and laundry and may qualify as a setting that allows residents to receive home and community-based services funded by state and federal programs;

(d) "Home health care agency" means a public or private organization, or a subdivision thereof, engaged in providing professional nursing services and the following services, available twenty-four hours per day, in the patient's home or a substantially equivalent environment: Home health aide services as defined in this section, physical therapy, speech therapy, occupational therapy or medical social services. The agency shall provide professional nursing services and at least one additional service directly and all others directly or through contract. An agency shall be available to enroll new patients seven days a week, twenty-four hours per day;

(e) "Home health aide agency" means a public or private organization, except a home health care agency, which provides in the patient's home or a substantially equivalent environment supportive services which may include, but are not limited to, assistance with personal hygiene, dressing, feeding and incidental household tasks

essential to achieving adequate household and family management. Such supportive services shall be provided under the supervision of a registered nurse and, if such nurse determines appropriate, shall be provided by a social worker, physical therapist, speech therapist or occupational therapist. Such supervision may be provided directly or through contract;

(f) "Home health aide services" as defined in this section shall not include services provided to assist individuals with activities of daily living when such individuals have a disease or condition that is chronic and stable as determined by a physician licensed in the state;

(g) "Behavioral health facility" means any facility that provides mental health services to persons eighteen years of age or older or substance use disorder services to persons of any age in an outpatient treatment or residential setting to ameliorate mental, emotional, behavioral or substance use disorder issues;

(h) "Clinical laboratory" means any facility or other area used for microbiological, serological, chemical, hematological, immunohematological, biophysical, cytological, pathological or other examinations of human body fluids, secretions, excretions or excised or exfoliated tissues for the purpose of providing information for the (1) diagnosis, prevention or treatment of any human disease or impairment, (2) assessment of human health, or (3) assessment of the presence of drugs, poisons or other toxicological substances;

(i) "Person" means any individual, firm, partnership, corporation, limited liability company or association;

(j) "Commissioner" means the Commissioner of Public Health or the commissioner's designee;

(k) "Home health agency" means an agency licensed as a home health care agency or a home health aide agency;

(l) "Assisted living services agency" means an agency that provides, among other things, nursing services and assistance with activities of

daily living to a population that is chronic and stable and may have a dementia special care unit or program as defined in section 19a-562;

(m) "Outpatient clinic" means an organization operated by a municipality or a corporation, other than a hospital, that provides (1) ambulatory medical care, including preventive and health promotion services, (2) dental care, or (3) mental health services in conjunction with medical or dental care for the purpose of diagnosing or treating a health condition that does not require the patient's overnight care;

(n) "Multicare institution" means a hospital that provides outpatient behavioral health services or other health care services, psychiatric outpatient clinic for adults, free-standing facility for the care or treatment of substance abusive or dependent persons, hospital for psychiatric disabilities, as defined in section 17a-495, or a general acute care hospital that provides outpatient behavioral health services that (1) is licensed in accordance with this chapter, (2) has more than one facility or one or more satellite units owned and operated by a single licensee, and (3) offers complex patient health care services at each facility or satellite unit. For purposes of this subsection, "satellite unit" means a location where a segregated unit of services is provided by the multicare institution;

(o) "Nursing home" or "nursing home facility" means (1) any chronic and convalescent nursing home or any rest home with nursing supervision that provides nursing supervision under a medical director twenty-four hours per day, or (2) any chronic and convalescent nursing home that provides skilled nursing care under medical supervision and direction to carry out nonsurgical treatment and dietary procedures for chronic diseases, convalescent stages, acute diseases or injuries;

(p) "Outpatient dialysis unit" means (1) an out-of-hospital out-patient dialysis unit that is licensed by the department to provide (A) services on an out-patient basis to persons requiring dialysis on a short-term basis or for a chronic condition, or (B) training for home dialysis, or (2) an in-hospital dialysis unit that is a special unit of a licensed hospital designed, equipped and staffed to (A) offer dialysis therapy on an out-

patient basis, (B) provide training for home dialysis, and (C) perform renal transplantations;

(q) "Hospice agency" means a public or private organization that provides home care and hospice services to terminally ill patients;

(r) "Psychiatric residential treatment facility" means a nonhospital facility with a provider agreement with the Department of Social Services to provide inpatient services to Medicaid-eligible individuals under the age of twenty-one; **[**and**]**

(s) "Chronic disease hospital" means a long-term hospital having facilities, medical staff and all necessary personnel for the diagnosis, care and treatment of chronic diseases; and

(t) "Birth center" means a freestanding facility that is licensed by the department (1) to provide prenatal, labor, delivery and postpartum care during and immediately after delivery to persons presenting with a low-risk pregnancy and healthy newborns for a period typically less than twenty-four hours, and (2) that is not a hospital licensed pursuant to the provisions of this chapter, or attached to or located in such a hospital. For the purposes of this subsection, "low-risk pregnancy" means an uncomplicated, singleton pregnancy that has vertex presentation and is at low risk for developing complications during labor and birth, as determined by an evaluation and examination conducted by a licensed physician or other licensed practitioner acting within the scope of such practitioner's practice.

Sec. 2. (NEW) (*Effective October 1, 2023*) (a) On and after January 1, 2024, no person, entity, firm, partnership, corporation, limited liability company or association shall establish, conduct, operate or maintain a birth center, as defined in section 19a-490 of the general statutes, as amended by this act, in this state without obtaining a license in accordance with the provisions of chapter 368v of the general statutes. An outpatient clinic shall not provide any birth center services without being licensed as a birth center pursuant to the provisions of chapter 368v of the general statutes. For the purposes of this subsection, "birth

center services" means prenatal, labor, delivery and postpartum care during and immediately after delivery to persons presenting with a low-risk pregnancy and healthy newborns for a period typically less than twenty-four hours and "low-risk pregnancy" has the same meaning as provided in subsection (t) of section 19a-490 of the general statutes, as amended by this act.

(b) Each applicant for licensure as a birth center shall be accredited by the Commission for the Accreditation of Birth Centers at the time it submits an application for licensure to the Department of Public Health and maintain such accreditation during the time it is licensed. If a birth center loses its accreditation, the birth center shall immediately notify the Commissioner of Public Health and cease providing birth center services to patients until authorized by the commissioner to reinstate such services.

(c) Each birth center shall have a written plan to obtain services from a hospital, licensed pursuant to chapter 368v of the general statutes, to provide obstetrical, pediatric and neonatal services in the event of an emergency or other conditions that pose a risk to the health of a patient that require transfer of the patient to a hospital. No hospital shall refuse to enter into or terminate an agreement with a birth center for the implementation of such plan without the commissioner's approval.

(d) The commissioner may adopt regulations, in accordance with the provisions of chapter 54 of the general statutes, to implement the provisions of this section and section 19a-495 of the general statutes. Such regulations may include, but need not be limited to, provisions regarding the administration of the facility, staffing requirements, infection control protocols, physical plant requirements, accommodation of the participation of support persons of the patient's choice, limitations on the provision of anesthesia and surgical procedures, operating procedures for determining risk status of patients at admission and during labor, reportable events, medical records, pharmaceutical services, laundry services and emergency planning. The commissioner may implement policies and procedures necessary to

administer the provisions of this section while in the process of adopting such policies and procedures as regulations, provided notice of intent to adopt regulations is published on the eRegulations System not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this subsection shall be valid until the date on which final regulations are adopted.

Sec. 3. Subsection (c) of section 19a-491 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(c) **[**Notwithstanding any regulation, the**]** The Commissioner of Public Health shall charge the following fees for the biennial licensing and inspection of the following institutions: (1) Chronic and convalescent nursing homes, per site, four hundred forty dollars; (2) chronic and convalescent nursing homes, per bed, five dollars; (3) rest homes with nursing supervision, per site, four hundred forty dollars; (4) rest homes with nursing supervision, per bed, five dollars; (5) outpatient dialysis units and outpatient surgical facilities, six hundred twenty-five dollars; (6) mental health residential facilities, per site, three hundred seventy-five dollars; (7) mental health residential facilities, per bed, five dollars; (8) hospitals, per site, nine hundred forty dollars; (9) hospitals, per bed, seven dollars and fifty cents; (10) nonstate agency educational institutions, per infirmary, one hundred fifty dollars; (11) nonstate agency educational institutions, per infirmary bed, twenty-five dollars; (12) home health care agencies, except certified home health care agencies described in subsection (d) of this section, per agency, three hundred dollars; (13) home health care agencies, hospice agencies or home health aide agencies, except certified home health care agencies, hospice agencies or home health aide agencies described in subsection (d) of this section, per satellite patient service office, one hundred dollars; (14) assisted living services agencies, except such agencies participating in the congregate housing facility pilot program described in section 8-119n, per site, five hundred dollars; (15) short-term hospitals special hospice, per site, nine hundred forty dollars; (16) short-term hospitals special hospice, per bed, seven dollars and fifty cents; (17)

hospice inpatient facility, per site, four hundred forty dollars; **[**and**]** (18) hospice inpatient facility, per bed, five dollars; and (19) birth centers, per site, nine hundred forty dollars and, per bed, seven dollars and fifty cents.

Sec. 4. Section 20-86b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

Nurse-midwives shall practice within a health care system or birth center and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. Nurse-midwifery care shall be consistent with the standards of care established by the Accreditation Commission for Midwifery Education. Each nurse-midwife shall provide each patient with information regarding, or referral to, other providers and services upon request of the patient or when the care required by the patient is not within the midwife's scope of practice. Each nurse-midwife shall sign the birth certificate of each infant delivered by the nurse-midwife. If an infant is born alive and then dies within the twenty-four-hour period after birth, the nurse-midwife may make the actual determination and pronouncement of death provided: (1) The death is an anticipated death; (2) the nurse-midwife attests to such pronouncement on the certificate of death; and (3) the nurse-midwife or a physician licensed pursuant to chapter 370 certifies the certificate of death not later than twenty-four hours after such pronouncement. In a case of fetal death, as described in section 7-60, the nurse-midwife who delivered the fetus may make the actual determination of fetal death and certify the date of delivery and that the fetus was born dead.

Sec. 5. Section 19a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) No person shall keep a maternity hospital or lying-in place unless such person has previously obtained a license therefor, issued by the Department of Public Health. Each such license shall be valid for a term of two years and may be revoked by the Department of Public Health

upon proof that the institution for which such license was issued is being improperly conducted or for the violation of any of the provisions of this section or of the Public Health Code, or on the basis of lack of demonstrable need, provided the licensee shall be given a reasonable opportunity to be heard in reference to such proposed revocation.

(b) Within six hours after the departure, removal or withdrawal of any child born at such maternity hospital or lying-in place, the keeper thereof shall make a record of such departure, removal or withdrawal of such child, the names and residences of the persons who took such child or its body and the place to which it was taken and where it was left, which record shall be produced by the keeper or licensee of such hospital or lying-in place, for inspection by and upon the demand of any person authorized to make such inspection by the Department of Public Health or the council. Each keeper of any such hospital or lying-in place, and his servants and agents, shall permit any person so authorized to enter such hospital or lying-in place and inspect such hospital or lying-in place and all of its appurtenances, for the purpose of detecting any improper treatment of any child or any improper management or conduct in such hospital or lying-in place or its appurtenances. Each person so authorized may remove any article which he may think presents evidence of any crime being committed therein and deliver the same to the appropriate law enforcement official to be disposed of according to law. Any person who violates any provision of this section shall be fined not more than two hundred dollars or imprisoned not more than six months or both.

(c) On and after January 1, 2024, the Commissioner of Public Health shall not grant or renew a maternity hospital license pursuant to this section.

Sec. 6. Subsection (b) of section 19a-638 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2024*):

(b) A certificate of need shall not be required for:

(1) Health care facilities owned and operated by the federal government;

(2) The establishment of offices by a licensed private practitioner, whether for individual or group practice, except when a certificate of need is required in accordance with the requirements of section 19a-493b or subdivision (3), (10) or (11) of subsection (a) of this section;

(3) A health care facility operated by a religious group that exclusively relies upon spiritual means through prayer for healing;

(4) Residential care homes, as defined in subsection (c) of section 19a-490, as amended by this act, and nursing homes and rest homes, as defined in subsection (o) of section 19a-490, as amended by this act;

(5) An assisted living services agency, as defined in section 19a-490, as amended by this act;

(6) Home health agencies, as defined in section 19a-490, as amended by this act;

(7) Hospice services, as described in section 19a-122b;

(8) Outpatient rehabilitation facilities;

(9) Outpatient chronic dialysis services;

(10) Transplant services;

(11) Free clinics, as defined in section 19a-630;

(12) School-based health centers and expanded school health sites, as such terms are defined in section 19a-6r, community health centers, as defined in section 19a-490a, not-for-profit outpatient clinics licensed in accordance with the provisions of chapter 368v and federally qualified health centers;

(13) A program licensed or funded by the Department of Children and Families, provided such program is not a psychiatric residential

treatment facility;

(14) Any nonprofit facility, institution or provider that has a contract with, or is certified or licensed to provide a service for, a state agency or department for a service that would otherwise require a certificate of need. The provisions of this subdivision shall not apply to a short-term acute care general hospital or children's hospital, or a hospital or other facility or institution operated by the state that provides services that are eligible for reimbursement under Title XVIII or XIX of the federal Social Security Act, 42 USC 301, as amended;

(15) A health care facility operated by a nonprofit educational institution exclusively for students, faculty and staff of such institution and their dependents;

(16) An outpatient clinic or program operated exclusively by or contracted to be operated exclusively by a municipality, municipal agency, municipal board of education or a health district, as described in section 19a-241;

(17) A residential facility for persons with intellectual disability licensed pursuant to section 17a-227 and certified to participate in the Title XIX Medicaid program as an intermediate care facility for individuals with intellectual disabilities;

(18) Replacement of existing imaging equipment if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the unit of the date on which the equipment is replaced and the disposition of the replaced equipment;

(19) Acquisition of cone-beam dental imaging equipment that is to be used exclusively by a dentist licensed pursuant to chapter 379;

(20) The partial or total elimination of services provided by an outpatient surgical facility, as defined in section 19a-493b, except as provided in subdivision (6) of subsection (a) of this section and section 19a-639e;

(21) The termination of services for which the Department of Public Health has requested the facility to relinquish its license;

(22) Acquisition of any equipment by any person that is to be used exclusively for scientific research that is not conducted on humans; **[**or**]**

(23) On or before June 30, 2026, an increase in the licensed bed capacity of a mental health facility, provided (A) the mental health facility demonstrates to the unit, in a form and manner prescribed by the unit, that it accepts reimbursement for any covered benefit provided to a covered individual under: (i) An individual or group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469; (ii) a self-insured employee welfare benefit plan established pursuant to the federal Employee Retirement Income Security Act of 1974, as amended from time to time; or (iii) HUSKY Health, as defined in section 17b-290, and (B) if the mental health facility does not accept or stops accepting reimbursement for any covered benefit provided to a covered individual under a policy, plan or program described in clause (i), (ii) or (iii) of subparagraph (A) of this subdivision, a certificate of need for such increase in the licensed bed capacity shall be required; or

(24) A birth center, as defined in section 19a-490, as amended by this act.

Sec. 7. (NEW) (*Effective October 1, 2023*) (a) As used in this section and section 8 of this act, "infant death" means the death of a child that occurs between birth and one year of age.

(b) There is established, within the Department of Public Health, an infant mortality review program. The purpose of the program shall be to review medical records and other relevant data related to infant deaths, including, but not limited to, information collected from death and birth records, and medical records from health care providers and health care facilities for the purposes of making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(c) All health care providers, health care facilities and pharmacies shall provide the Commissioner of Public Health, or the commissioner's designee, with access to all medical and other records associated with an infant death case under review by the program, including, but not limited to, prenatal care records, upon the request of the commissioner.

(d) A person who completes a death certificate pursuant to section 7-62b or section 19a-409 of the general statutes for an infant death shall report such death to the department in a form and manner prescribed by the commissioner.

(e) Notwithstanding any provision of the general statutes, the commissioner shall notify the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, of an infant death if, pursuant to a review performed by the infant mortality review program, the commissioner determines that such infant death occurred in out-of-home care or was due to unexpected or unexplained causes.

(f) All information obtained by the commissioner, or the commissioner's designee, for the infant mortality review program shall be confidential pursuant to section 19a-25 of the general statutes, as amended by this act.

(g) Notwithstanding any provision of the general statutes, the commissioner, or the commissioner's designee may provide the infant mortality review committee, established pursuant to section 8 of this act, with information as is necessary, in the commissioner's discretion, for the committee to make recommendations regarding the prevention of infant deaths.

(h) The provisions of this section and section 8 of this act shall not be construed to limit or alter the authority of the Office of the Child Advocate or the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, to investigate or make recommendations regarding a child's death pursuant to the provisions of said section.

Sec. 8. (NEW) (*Effective October 1, 2023*) (a) There is established an infant mortality review committee within the department to conduct a comprehensive, multidisciplinary review of infant deaths for purposes of reducing health care disparities, identifying factors associated with infant deaths and making recommendations to reduce infant deaths.

(b) The cochairpersons of the infant mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut chapter of the American Academy of Pediatrics. The cochairpersons shall convene a meeting of the infant mortality review committee upon the request of the Commissioner of Public Health.

(c) The infant mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on the infant death case being reviewed:

(1) A physician licensed pursuant to chapter 370 of the general statutes, who specializes in obstetrics and gynecology, designated by the Connecticut Chapter of the American College of Obstetrics and Gynecology;

(2) A community health worker, designated by the Commission on Women, Children, Seniors, Equity and Opportunity;

(3) A pediatric nurse licensed pursuant to chapter 378 of the general statutes, designated by the Connecticut Nurses Association;

(4) A clinical social worker licensed pursuant to chapter 383b of the general statutes, designated by the Connecticut Chapter of the National Association of Social Workers;

(5) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(6) A member of the Connecticut Hospital Association representing a pediatric facility;

(7) A representative of The University of Connecticut-sponsored Health Disparities Institute;

(8) A physician licensed pursuant to chapter 370 of the general statutes, who practices neonatology, designated by the Connecticut Medical Society;

(9) A physician assistant licensed pursuant to chapter 370 of the general statutes or advanced practice registered nurse licensed pursuant to chapter 378 of the general statutes, designated by an association representing physician assistants or advanced practice registered nurses in the state;

(10) The Child Advocate, or the Child Advocate's designee;

(11) The Commissioner of Social Services, or the commissioner's designee;

(12) The Commissioner of Children and Families, or the commissioner's designee;

(13) The Commissioner of Early Childhood, or the commissioner's designee;

(14) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(15) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.

(d) For any infant mortality review, the committee may consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section 7 of this act and make recommendations regarding the prevention of infant deaths.

(e) The infant mortality review committee shall include available infant death reports and recommendations produced by the child fatality review panel, established pursuant to section 46a-13*l* of the general statutes, in its review of infant deaths for the purposes of

making recommendations to reduce health care disparities and identify gaps in or problems with the delivery of care or services to reduce infant deaths.

(f) Not later than ninety days after completing an infant mortality review, the committee shall, in consultation with the Office of the Child Advocate, report to the Commissioner of Public Health the recommendations and findings of the committee in a manner that complies with section 19a-25 of the general statutes, as amended by this act.

(g) All information provided by the department to the infant mortality review committee or provided to any expert consulted by the committee shall be subject to the provisions of section 19a-25 of the general statutes, as amended by this act.

Sec. 9. Subsection (a) of section 19a-25 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2023*):

(a) All information, records of interviews, written reports, statements, notes, memoranda or other data, including personal data as defined in subdivision (9) of section 4-190, procured by: (1) The Department of Public Health, by staff committees of facilities accredited by the Department of Public Health, **[**or**]** the maternity mortality review committee, established pursuant to section 19a-59i, or the infant mortality review committee, established pursuant to section 8 of this act, in connection with studies of morbidity and mortality conducted by the Department of Public Health, such staff committees, **[**or**]** the maternal mortality review committee or the infant mortality review committee, or carried on by said department, such staff committees or the maternal mortality review committee jointly with other persons, agencies or organizations, (2) the directors of health of towns, cities or boroughs or the Department of Public Health pursuant to section 19a-215, or (3) the Department of Public Health or such other persons, agencies or organizations, for the purpose of reducing the morbidity or mortality from any cause or condition, shall be confidential and shall be used

solely for the purposes of medical or scientific research and, for information obtained pursuant to section 19a-215, disease prevention and control by the local director of health and the Department of Public Health and reducing the morbidity or mortality from any cause or condition. Such information, records, reports, statements, notes, memoranda or other data shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency or person, nor shall it be exhibited or its contents disclosed in any way, in whole or in part, by any officer or representative of the Department of Public Health or of any such facility, by any person participating in such a research project or by any other person, except as may be necessary for the purpose of furthering the research project or public health use to which it relates.

Sec. 10. (NEW) (*Effective July 1, 2023*) (a) As used in this section, (1) "certified doula" means a doula who is certified by the Department of Public Health, and (2) "doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person and any family or friends supporting such person before, during and after birth.

(b) The Doula Advisory Committee, established pursuant to section 40 of public act 22-58, shall advise the Commissioner of Public Health, or the commissioner's designee, on matters relating to doula services, including, but not limited to, (1) access and promotion of education and resources for pregnant persons, and any family and friends supporting such person; (2) recommendations to improve access to doula care; and (3) furthering interagency efforts to address maternal health disparities. The committee shall decide to renew or disband the committee on an annual basis in a manner determined by the commissioner or the commissioner's designee.

(c) The Doula Training Program Review Committee, established pursuant to section 40 of public act 22-58, shall (1) conduct an ongoing review of doula education and training programs; (2) provide the commissioner, or the commissioner's designee, with a list of approved

doula education and training programs, which shall include training in core doula competencies; and (3) recommend certified doula continuing education requirements to the commissioner.

(d) On and after October 1, 2023, no person shall use the title "certified doula" unless such person is certified pursuant to this section.

(e) Each person seeking certification to practice as a certified doula shall apply to the Department of Public Health, on forms prescribed by the commissioner, and pay an application fee of one hundred dollars. Such application shall include: (1) Proof that the applicant is eighteen years of age or older; (2) two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula verifying the applicant's training or experience; and (3) (A) demonstration of the applicant's completion of a doula training program or a combination of such programs approved pursuant to subsection (c) of this section, or (B) an attestation by the applicant that such applicant has provided doula services to at least three families during the five years preceding the date of the application.

(f) The commissioner may grant certification by endorsement to a doula who presents evidence satisfactory to the commissioner that the applicant is certified as a doula in another state or jurisdiction whose requirements for certification are substantially similar to those of this state. No certification shall be issued under this section to any applicant against whom professional disciplinary action is pending or who is the subject of an unresolved complaint.

(g) The commissioner shall adopt continuing education requirements for certified doulas provided by the Doula Training Program Review Committee pursuant to subsection (c) of this section.

(h) Certification issued under this section may be renewed every three years. The certification shall be renewed in accordance with the provisions for renewal under section 19a-88 of the general statutes for a fee of one hundred dollars. Each certified doula applying for renewal shall provide to the commissioner evidence of completion of the

continuing education requirements adopted pursuant to subsection (g) of this section.

(i) The commissioner may take any disciplinary action set forth in section 19a-17 of the general statutes against a certified doula for failure to conform to the accepted standards of the profession including, but not limited to, any of the following reasons: (1) Fraud or deceit in obtaining or seeking reinstatement of a certification to practice as a certified doula; (2) engaging in fraud or material deception in the course of professional services or activities; (3) negligent, incompetent or wrongful conduct in professional activities; (4) aiding or abetting the use of the title "certified doula" by an individual who is not certified; (5) physical, mental or emotional illness or disorder resulting in an inability to conform to the accepted standards of the profession; or (6) abuse or excessive use of drugs, including alcohol, narcotics or chemicals. The commissioner may order a certified doula to submit to a reasonable physical or mental examination if such certified doula's physical or mental capacity to practice safely is the subject of an investigation. The commissioner may petition the superior court for the judicial district of Hartford to enforce such order or any action taken pursuant to section 19a-17 of the general statutes. The commissioner shall give notice and an opportunity to be heard on any contemplated action under section 19a-17 of the general statutes.

Sec. 11. (NEW) (*Effective July 1, 2023*) (a) As used in this section:

(1) "Certified midwife" means any individual who completes a graduate degree in midwifery and passes a national certification examination administered by the American Midwifery Certification Board to receive the professional designation of certified midwife;

(2) "Community birth" means a planned home birth or a birth occurring at a birth center;

(3) "Direct entry midwife" means any individual trained in planned out-of-hospital births other than a nurse-midwife, which may include certified midwives, certified professional midwives, community

midwives and traditional midwives; and

(4) "Licensed nurse-midwife" means any individual licensed as a nurse-midwife pursuant to chapter 377 of the general statutes.

(b) The Commissioner of Public Health shall establish a midwifery working group. The working group shall study and make recommendations concerning the advancement of choices in care for community birth and the role of community midwives in addressing maternal and infant health disparities. Such study shall include, but need not be limited to:

(1) Improvements in birthing care quality and safety, including improvements addressing racial disparities in maternal and infant health outcomes;

(2) Regulation, licensure or certification of direct entry midwives not otherwise licensed to practice midwifery in the state;

(3) Regulation, licensure or certification of certified midwives not otherwise licensed to practice midwifery in the state; and

(4) Advancements of interprofessional coordination of birthing care, including community birth.

(c) The Commissioner of Public Health shall appoint members of the working group. Such members shall include, but need not be limited to, the commissioner's designee, at least six direct-entry midwives practicing in the state, a certified nurse-midwife with experience working with direct entry midwives, a certified midwife representing an entity that certifies midwives, a doula serving communities of color, a representative of families or a community-based organization with an interest in maternity care, a representative of a community organization furthering health equity, representatives of associated maternity care professions, a representative of the state hospital association and a representative of the Department of Social Services.

(d) Not later than February 1, 2024, and annually thereafter, the

midwifery working group shall report to the Commissioner of Public Health and, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health on its findings and recommendations.

(e) The midwifery working group shall select to renew or disband the group on an annual basis in a manner determined by the commissioner or the commissioner's designee.

Sec. 12. (NEW) (*Effective July 1, 2023*) (a) As used in this section, "universal newborn nurse home visiting" means an evidence-based nurse home visiting model in which a registered nurse, licensed pursuant to chapter 378 of the general statutes, with specialized training provides services in the home to families with newborns in accordance with the provisions of this section.

(b) The Commissioner of Early Childhood, in collaboration with the Commissioners of Social Services and Public Health and the Executive Director of the Office of Health Strategy, shall, within available appropriations, develop and implement a state-wide program to offer universal newborn nurse home visiting services to all families with newborns residing in the state to support parental health, healthy child development and strengthen families.

(c) When developing the program, said commissioners and executive director, shall (1) consult with insurers that offer health benefit plans in the state, hospitals, local public health authorities, existing early childhood home visiting programs, community-based organizations and social service providers; and (2) maximize the use of available federal funding.

(d) The program shall provide universal newborn nurse home visiting services that are (1) evidence-based, and (2) designed to improve outcomes in one or more of the following areas: (A) Child safety; (B) child health and development; (C) family economic self-sufficiency; (D) maternal and parental health; (E) positive parenting; (F)

reducing child mistreatment; (G) reducing family violence; (H) parent-infant bonding; and (I) any other appropriate area established, in writing, by the Commissioners of Early Childhood, Social Services and Public Health and the Executive Director of the Office of Health Strategy.

(e) The universal newborn nurse home visiting services provided pursuant to the program shall: (1) Be voluntary and carry no negative consequences for a family that declines to participate; (2) be offered in every community in the state; (3) include an evidence-based assessment of the physical, social and emotional factors affecting a family receiving such services; (4) be offered to all families with newborns based on the full extent of available provider capacity; (5) include at least one visit during a newborn's first three months of life or other timeframe as deemed appropriate by said commissioners and executive director; (6) allow families to choose up to a certain number of additional visits consistent with an evidence-based model; (7) include a follow-up visit no later than three months or other time frame established by such model after the last visit; and (8) provide information and referrals to address each family's identified needs.

(f) The Commissioner of Social Services may seek approval of an amendment to the state Medicaid plan or a waiver from federal law to provide coverage for universal newborn nurse home visiting services provided pursuant to this section and in a time frame and manner to ensure that such coverage does not duplicate other applicable federal funding.

(g) The Commissioner of Early Childhood, in collaboration with the Commissioners of Social Services and Public Health and the executive director of the Office of Health Strategy, shall collect and analyze data generated by the program to assess the effectiveness of the program in meeting the goals described in subsection (d) of this section and collaborate with other state agencies to develop protocols for sharing such data, including the timely sharing of data with primary care providers that provide care to families with newborns receiving

universal newborn nurse home visiting services pursuant to the provisions of this section.

Sec. 13. Section 19a-505 of the general statutes is repealed. (*Effective July 1, 2025*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2024*	19a-490
Sec. 2	*October 1, 2023*	New section
Sec. 3	*January 1, 2024*	19a-491(c)
Sec. 4	*January 1, 2024*	20-86b
Sec. 5	*October 1, 2023*	19a-505
Sec. 6	*January 1, 2024*	19a-638(b)
Sec. 7	*October 1, 2023*	New section
Sec. 8	*October 1, 2023*	New section
Sec. 9	*October 1, 2023*	19a-25(a)
Sec. 10	*July 1, 2023*	New section
Sec. 11	*July 1, 2023*	New section
Sec. 12	*July 1, 2023*	New section
Sec. 13	*July 1, 2025*	Repealer section

PH *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 24 $	FY 25 $
Resources of the General Fund	GF - Revenue Gain	985	None
Resources of the General Fund	GF - Revenue Loss	985	None
Public Health, Dept.	GF - Cost	90,970	96,444
State Comptroller - Fringe Benefits[1]	GF - Cost	38,953	41,297
Resources of the General Fund	GF - Revenue Gain	5,000	5,000
Office of Early Childhood	GF - Potential Cost	See Below	See Below
Social Services, Dept.	GF - Potential Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

The bill results in various fiscal impacts, identified by section below.

Section 3, which establishes Birth Center biennial licensure of $940 per site and $7.5 per bed, results in a General Fund revenue gain of $985 in FY 24. There is currently one Maternity Hospital licensed by the Department of Public Health (DPH) in Danbury. It is the Connecticut Childbirth & Women's Center, and it is the only facility to hold accreditation by the Commission for the Accreditation of Birth Centers

[1]The fringe benefit costs for most state employees are budgeted centrally in accounts administered by the Comptroller. The estimated active employee fringe benefit cost associated with most personnel changes is 42.82% of payroll in FY 24.

in Connecticut. It has six beds. It is anticipated to seek Birth Center licensure in FY 24.

Section 6, which directs DPH to not grant or renew Maternity Hospital licensure on and after 1/1/24, results in a General Fund revenue loss of $985 in FY 24. CGS Sec. 19a-491 sets the biennial licensure fee for Maternity Hospitals at of $940 per site and $7.5 per bed.

Section 7, which establishes a Public Health Infant Mortality Review program in DPH, results in a cost to the agency of $90,970 in FY 24 and $96,444 in FY 25 and fringe benefit costs of $38,953 in FY 24 and $41,297 in FY 25 for a Nurse Consultant to study infant deaths and produce recommendations on how to reduce them.

Section 10, which establishes doula certification for a fee of $100, results in a revenue gain to the General Fund of approximately $5,000 in FY 24 and FY 25. It is anticipated that DPH's Practitioner Licensing and Investigations Section can accommodate certification of approximately 50 doulas annually with existing staff and resources. Doula certification may be renewed every three years.

Section 12 results in a potential cost to the Office of Early Childhood (OEC) to establish a statewide universal newborn nurse home visiting program, within available appropriations. This section also allows the Department of Social Services (DSS) to seek approval of an amendment to the Medicaid state plan or waiver to provide coverage of universal newborn nurse home visiting services. This results in a cost to DSS to the extent that related services are billed under Medicaid.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, the number of doulas that seek DPH certification, funding available to OEC for the universal newborn nurse home visiting program, and the extent to which services for this program are billed under Medicaid.

OLR Bill Analysis

sSB 986

AN ACT PROTECTING MATERNAL HEALTH.

SUMMARY

This bill makes various unrelated changes affecting maternal and infant health. Principally, it:

1. creates a new license category for freestanding birth centers administered by the Department of Public Health (DPH), and starting January 1, 2024, prohibits anyone from establishing or operating a birth center unless it obtains this license (§§ 1-6);

2. prohibits DPH from issuing or renewing a maternity hospital license starting January 1, 2024, and repeals this licensure program on July 1, 2025 (§§ 5 & 13);

3. establishes an Infant Mortality Relief Program within DPH to review medical records and other data on infant deaths (i.e., those occurring between birth and one year of age) and sets related requirements on record access, information sharing, and confidentiality (§§ 7 & 9);

4. establishes an Infant Mortality Review Committee within DPH to conduct a comprehensive, multidisciplinary review of infant deaths to reduce health care disparities, identify associated factors, and make recommendations to reduce the deaths (§§ 8 & 9);

5. establishes a voluntary doula certification program administered by DPH and, starting October 1, 2023, prohibits someone from using the title "certified doula" unless they are certified (§ 10);

6. expands the duties of DPH's Doula Advisory Committee and Doula Training Program Review Committee to include responsibilities related to the new doula certification program (§ 10);

7. requires the DPH commissioner to create a midwifery working group to study and make recommendations on advancing choices for community birth care (i.e., planned home birth or birth at a birth center) and the role of community midwives in addressing maternal and infant health disparities (§ 11); and

8. requires the Office of Early Childhood (OEC) commissioner, within available appropriations, to develop and implement a statewide universal nurse home visiting services program for all families with newborns living in the state (§ 12).

The bill also makes technical and conforming changes.

EFFECTIVE DATE: October 1, 2023, except that provisions on (1) birth center licensure take effect on January 1, 2024; (2) doula certification, the midwifery working group, and the universal nurse home visiting services program take effect July 1, 2023; and (3) repealing the maternity hospital licensure program take effect July 1, 2025.

§§ 1-6 & 13 — BIRTH CENTER LICENSURE

The bill creates a new license category for freestanding birth centers administered by DPH. Starting January 1, 2024, it prohibits a person, entity, firm, partnership, corporation, limited liability company, or association from establishing, conducting, operating, or maintaining a birth center unless it obtains this license. The bill also expressly prohibits an outpatient clinic from providing birth center services without a birth center license.

Also starting on this date, the bill prohibits the DPH commissioner from granting or renewing a maternity hospital license. It then repeals the maternity hospital licensure program on July 1, 2025. (The one facility that currently holds this license will presumably transfer to the

new birth center license.)

Definitions

Under the bill, a "birth center" is a freestanding DPH-licensed facility that provides prenatal, labor, delivery, and postpartum care during and immediately after delivery to those presenting with a low-risk pregnancy and healthy newborns for generally less than 24 hours. It is not a licensed hospital or attached to or located in a licensed hospital.

A "low-risk pregnancy" is an uncomplicated, single-fetus pregnancy with vertex presentation (i.e., positioned head-first) that is at low risk of developing complications during labor and delivery, as a licensed practitioner, acting within his or her scope of practice, determines through an evaluation and examination.

The bill also makes a conforming change by adding "birth center" to the statutory definition of health care "institution." In doing so, the bill extends to these centers statutory requirements for health care institutions on things like workplace safety committees, patient record access, HIV-related information disclosure, and smoking prohibitions.

Licensure Application

Under the bill, licensure applicants must be accredited by the Commission for the Accreditation of Birth Centers and maintain accreditation when they are licensed. If a birth center loses accreditation, it must immediately notify the DPH commissioner and stop providing birth center services to patients until the commissioner authorizes it to reinstate services.

Licensure Fees

Under the bill, DPH must license and inspect birth centers every two years. Birth centers must pay an initial and renewal license fee of $940 per site and $7.50 per bed.

Emergency Plan

The bill requires birth centers to have a written plan to get obstetrical, neonatal, and pediatric services from a licensed hospital if there is an

emergency or other conditions that pose a risk to the patient's health and require the patient's transfer to a hospital.

The bill prohibits hospitals from refusing to enter into or terminating an agreement with a birth center to implement the plan without the DPH commissioner's approval.

Nurse Midwife Practice

Under current law, nurse midwives must practice within a health care system and have a clinical relationship with obstetrician-gynecologists that provide for consultation, collaborative management, or referral as indicated by the patient's health status. The bill requires nurse midwives to instead practice either within a health care system or a birth center in the same manner.

Under existing law, unchanged by the bill, nurse midwives must provide (1) care consistent with standards the Accreditation Commission for Midwifery Education establishes and (2) information about, or referral to, other providers or services, if the patient asks or requires care that is not in the nurse-midwife's scope of practice.

Certificate of Need

The bill adds birth centers to the list of facilities exempt from the state's certificate of need (CON) requirements. By law, health care facilities must generally apply for and receive a CON from the Office of Health Strategy's Health Systems Planning Unit when proposing to (1) establish a new facility or provide new services, (2) change ownership, (3) purchase or acquire certain equipment, or (4) terminate certain services.

Regulations

The bill allows the DPH commissioner to adopt regulations to implement the licensure, including provisions on facility administration, staffing requirements, infection control protocols, physical plant requirements, accommodating participation of support people the patient chooses, limitations on providing anesthesia and surgical procedures, operating procedures for determining patients'

risk status at admission and during labor, reportable events, medical records, pharmaceutical services, laundry services, and emergency planning.

Under the bill, the commissioner may implement policies and procedures to administer the license while adopting them into regulations. However, she may only do this if she notifies her intent to adopt regulations in the eRegulations System within 20 days after the implementation date. These policies and procedures remain in effect until the final regulations are adopted.

§§ 7 & 9 — DPH INFANT MORTALITY REVIEW PROGRAM

The bill establishes an Infant Mortality Relief Program within DPH to review medical records and other relevant data on infant deaths.

Under the bill, this review must include information from birth and death records and medical records from health care providers and facilities to make recommendations on reducing health care disparities and identify gaps in, or problems with, health care or service delivery to reduce infant deaths.

Record Access and Information Sharing

Under the bill, pharmacies, health care providers, and facilities must give the DPH commissioner, or her designee, upon the commissioner's request, access to all medical and other records, including prenatal records, associated with infant death cases under the program's review.

The bill allows the commissioner or her designee, to give the Infant Mortality Review Committee (see § 8, below) information she determines it needs to make recommendations on infant death prevention.

Death Certificates

The bill requires the Office of the Chief Medical Examiner and funeral directors and licensed embalmers who complete a death certificate for an infant death to report the death to DPH in a way the commissioner sets.

Child Fatality Review Panel

The bill requires the DPH commissioner to notify the existing child fatality review panel about an infant death if the program reviews an infant death and determines that it occurred in out-of-home care or due to unexpected or unexplained causes.

The bill expressly provides that it does not limit or alter the authority of the Office of the Child Advocate or the child fatality review panel to investigate or make recommendations about a child's death.

By law, the child fatality review panel reviews the death of a child who was placed in out-of-home care or whose death was unexpected or unexplained to (1) develop prevention strategies to address identified trends and risk patterns and (2) improve service coordination for children and families (CGS § 46a-13*l*).

Confidentiality

Under the bill, the information the commissioner or her designee obtains for the program and all information DPH gives to the Infant Mortality Review Committee (see § 8, below) (1) is confidential and not subject to disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes (CGS § 19a-25).

§§ 8 & 9 — INFANT MORTALITY REVIEW COMMITTEE

The bill creates an Infant Mortality Review Committee within DPH to conduct a comprehensive, multidisciplinary review of infant deaths to reduce health care disparities, identify factors associated with infant deaths, and make recommendations to reduce these deaths.

Members

The bill allows the committee's membership to vary, as needed, depending on the infant death under review, but it may include the following members:

1. a licensed physician specializing in obstetrics and gynecology, designated by the American College of Obstetrics and

Gynecology's Connecticut chapter;

2. a community health worker, designated by the Commission on Women, Children, Seniors, Equity, and Opportunity;

3. a licensed pediatric nurse, designated by the Connecticut Nurses Association;

4. a licensed clinical social worker designated by the National Association of Social Workers Connecticut chapter;

5. the chief medical examiner, or his designee;

6. a Connecticut Hospital Association member representing a pediatric facility;

7. a representative of the UConn-sponsored Health Disparities Institute;

8. a licensed physician practicing neonatology, designated by the Connecticut Medical Society;

9. a licensed physician assistant (PA) or advanced practice registered nurse (APRN) designated by an association representing PAs or APRNs in Connecticut;

10. the child advocate, or her designee;

11. the commissioners of children and families, early childhood, mental health and addiction services, and social services, or their designees; and

12. any additional members the committee co-chairs determine would be beneficial.

Leadership and Meetings

Under the bill, the DPH commissioner, or her designee, and a representative designated by the American Academy of Pediatrics' Connecticut chapter, co-chair the committee. The co-chairs must

convene a committee meeting when the commissioner requests it.

Infant Mortality Reviews

The bill allows the committee, when conducting an infant mortality review, to consult with relevant experts to evaluate information and findings it obtains from the Infant Mortality Review Program (see above) and make recommendations on preventing infant deaths.

In its review, the committee must include available infant death reports and recommendations from the existing child fatality review panel to recommend ways to reduce health care disparities and identify gaps in, or problems with, delivering health care and services to reduce infant deaths.

Confidentiality

Under the bill, all information DPH gives the committee or an expert with whom the committee consults (1) is confidential and not subject to disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes (CGS § 19a-25).

Report

Within 90 days after completing an infant mortality review, the bill requires the committee, in consultation with the Office of the Child Advocate, to report its findings and recommendations to the DPH commissioner in a way that meets the confidentiality requirements.

§ 10 — DOULA CERTIFICATION

The bill generally implements the recommendations of DPH's Doula Advisory Committee created by PA 22-58, by establishing a DPH-administered voluntary doula certification program and related requirements. Starting October 1, 2023, it prohibits someone from using the title "certified doula" unless they obtain the certification.

The bill also expands the duties of DPH's Doula Advisory Committee and Doula Training Program Review Committee to include responsibilities related to the new doula certification program.

Under the bill, a "doula" is a trained, nonmedical professional who provides physical, emotional, and informational support, virtually or in person, to a pregnant person and any family or friends supporting them, during and after birth.

Doula Advisory Committee and Training Program Review Committee

Existing law requires DPH's Doula Advisory Committee to make recommendations on (1) doula certification requirements and (2) standards for recognizing doula training program curricula that meet the certification requirements.

The bill expands the advisory committee's duties to include advising the DPH commissioner or her designee on doula services matters, including (1) access and promotion of education and resources for pregnant persons, and family and friends supporting them; (2) recommendations to improve access to doula care; and (3) furthering interagency efforts to address maternal health disparities.

The bill requires DPH's Doula Training Program Review Committee to (1) conduct an ongoing review of doula education and training programs and (2) give the commissioner or her designee a list of approved doula education and training programs that meet the advisory committee's certification requirements. The bill also requires this committee to (1) ensure that its list of approved programs includes training in core doula competencies and (2) make recommendations on certified doula continuing education requirements to the commissioner.

The bill requires the advisory committee to annually decide whether to renew or disband in a manner the commissioner or her designee determines.

Certification Application

Under the bill, a doula must apply to DPH for certification on forms the commissioner sets and pay an application fee of $100.

The application must include the following information:

1. proof that the applicant is at least 18 years old,

2. two reference letters from families or professionals with direct knowledge of the applicant's experience as a doula that verify the applicant's training or experience, and

3. evidence that the applicant (a) completed a doula training program or a combination of programs approved by the Doula Advisory Committee or (b) attests that he or she provided doula services to at least three families during the five years preceding the application date.

The bill prohibits the commissioner from issuing a certificate to an applicant with pending professional disciplinary action or unresolved complaints against them.

Certification Renewal and Continuing Education

The bill requires doulas to renew their certification every three years and pay a $100 renewal fee.

Under the bill, DPH must adopt continuing education requirements for certified doulas, which the Doula Training Program Review Committee must provide. Certification renewal applicants must give DPH evidence of meeting the continuing education requirements.

Certification by Endorsement

The bill allows the DPH commissioner to grant certification by endorsement to a doula who presents satisfactory evidence that he or she is certified as a doula in another state or jurisdiction with certification requirements substantially similar to Connecticut's requirements.

Disciplinary Action

The bill authorizes the DPH commissioner to take several disciplinary actions against a certified doula, such as suspending or revoking the doula's certification, limiting his or her practice, and imposing a civil penalty of up to $25,000 (see CGS § 19a-17). The

commissioner may take these actions for a certified doula's failure to conform to accepted professional standards, including the following:

1. fraud or deceit in obtaining or seeking reinstatement of certification;

2. engaging in fraud or material deception in his or her professional services or activities;

3. negligent, incompetent, or wrongful conduct in professional activities;

4. aiding or abetting the use of the title "certified doula" by an uncertified person;

5. physical, mental, or emotional illness or disorder resulting in an inability to conform to accepted professional standards; or

6. drug abuse or excessive drug use, including alcohol, narcotics, or chemicals.

Under the bill, the commissioner may also order a certified doula to have a reasonable physical or mental examination if the doula's physical or mental capacity to safely practice is the subject of an investigation. The commissioner may also petition the Superior Court in Hartford to enforce an order or action she takes. The bill requires the commissioner to give the doula notice and an opportunity to be heard on any contemplated disciplinary action.

§ 11 — MIDWIFERY WORKING GROUP

The bill requires the DPH commissioner to create a midwifery working group to study and make recommendations on (1) advancing choices in care for community birth (i.e., planned home birth or birth at a birth center) and (2) community midwives' role in addressing maternal and infant health disparities.

Under the bill, the study must include the following:

1. improvements in birthing care quality and safety, including those addressing racial disparities in maternal and infant health outcomes;

2. regulation, licensure, or certification of direct entry midwives and certified midwives not otherwise licensed to practice midwifery in Connecticut; and

3. advancements of interprofessional coordination of birthing care, including community birth.

The working group must annually decide whether to renew or disband in a manner the DPH commissioner or her designee determines.

Members

The bill requires the DPH commissioner to appoint the working group members. It must at least include the following members:

1. a DPH commissioner designee and one Department of Social Services (DSS) representative,

2. at least six direct entry midwives practicing in Connecticut,

3. one certified nurse-midwife with experience working with direct entry midwives,

4. one certified midwife representing an entity that certifies midwives,

5. one doula serving communities of color,

6. one representative of families or a community-based organization with an interest in maternity care,

7. one representative of a community organization furthering health equity,

8. representatives of associated maternity care professions, and

9. one representative of the Connecticut Hospital Association.

Under the bill, a "direct entry midwife" is a person trained in planned out-of-hospital births other than a nurse-midwife, including certified midwives, certified professional midwives, community midwives, and traditional midwives.

A "certified midwife" is someone with a graduate degree in midwifery who passed a national certification examination administered by the American Midwifery Certification Board.

Report

The bill requires the working group, starting by February 1, 2024, to annually report its findings and recommendations to the DPH commissioner and the Public Health Committee.

§ 12 — UNIVERSAL NEWBORN HOME VISITING PROGRAM

The bill requires the OEC commissioner to develop and implement a statewide program offering universal nurse home visiting services to all families with newborns living in the state to support parental health, healthy child development, and strengthen families. She must do this within available appropriations, and in collaboration with the DSS and DPH commissioners and the Office of Health Strategy (OHS) executive director.

When developing the program, the commissioners and executive director must do the following:

1. consult with insurers that offer health benefit plans in the state, hospitals, local public health authorities, existing early childhood home visiting programs, community-based organizations, and social service providers and

2. maximize available federal funding.

Under the bill, "universal newborn nurse home visiting" is an evidence-based nurse home visiting model in which a licensed registered nurse with specialized training provides in-home services to

families with newborns.

Program Services

The program must provide universal newborn nurse home visiting services that are evidenced-based and designed to improve outcomes in one or more of the following areas:

1. child safety, health, and development;

2. family economic self-sufficiency;

3. maternal and parental health;

4. positive parenting and parent-infant bonding;

5. reducing child mistreatment and family violence; and

6. any other appropriate area the commissioners and executive director establish in writing.

Under the bill, the program's services must be (1) voluntary and have no negative consequences for a family that does not participate, (2) offered in every community in the state, and (3) offered to all families with newborns based on the full extent of available provider capacity. The services must also allow families to choose up to a certain number of additional visits, consistent with an evidence-based model; provide information and referrals to address each family's identified needs; and include the following:

1. an evidence-based assessment of the physical, social, and emotional factors affecting a family receiving these services;

2. at least one visit during a newborn's first three months or other timeframe the commissioners and executive director deem appropriate; and

3. a follow-up visit within three months or another time frame established by the model after the last visit.

Medicaid Waiver or State Plan Amendment

The bill authorizes the DSS commissioner to seek federal Centers for Medicare and Medicaid Services approval for a Medicaid state plan amendment or waiver for universal newborn nurse home visiting services coverage. The commissioner must do this in a time frame and manner to ensure that this coverage does not duplicate any other applicable federal funding.

Program Data

The bill requires the OEC commissioner, in collaboration with the DSS and DPH commissioners and OHS executive director, to collect and analyze program data to do the following:

1. assess the program's effectiveness in meeting its goals and

2. collaborate with other state agencies to develop protocols for sharing the data, including doing so in a timely manner with primary care providers that provide care to families with newborns receiving program services.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 26 Nay 11 (03/20/2023)